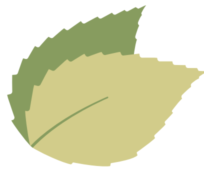


Zuidema & Hess
Family and Cosmetic Dentistry

WELCOME TO OUR OFFICE!

1 : A COUPLE QUESTIONS ABOUT YOU

Today's Date: ____ /____ /____

Instructional note: when answering questions with multiple choice options, please circle the answer(s) that apply to you.

Name: ____
FIRST MIDDLE LAST

Preferred Name: ______________________________ **Male** **Female**

Home Address: ____

____
CITY STATE ZIP CODE

Home Phone #: ____

Work Phone #: ____

Cell Phone #: ____

Email Address: ____

Birthday: ____ /____ /____ **Age:** ____

Social Security #: ____

Employer: ____

Occupation: ____

Who can we thank for referring you to our office?

Family ______________ **Friend** ______________ **Internet** ______________

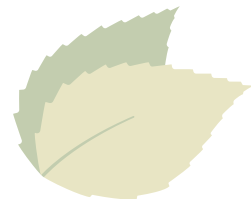
Yellow Pages ______________ **Radio** ______________ **Other** ______________

Other family members seen by us: **spouse** **children** **parents** **siblings**

Names: ____

In the event of an emergency, whom should we contact?

Their name: ______________ **Phone #:** ______________ **Relationship:** ______________



2 : DENTAL INSURANCE

Do you have dental insurance? **yes** **no**

Insured Name: ______________________________

Insured SS#: ______________________________

Insured Date of Birth: ____ /____ /____

Insured Employer: ______________________________

Insurance Co. Name: ______________________________

Insurance ID #: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone#: ______________________________

Group # (plan, local, or policy): ______________________________

Secondary Dental Insurance
If patient has secondary dental insurance and patient is covered under the policy, complete the following:

Insurance Co. Name: ______________________________

Insurance ID #: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group # (plan, local, or policy): ______________________________

Spouse's Name: ______________________________

Insured Date of Birth: ____ /____ /____ **SS#:** ______________________________

Spouse's Employer: ______________________________

Please list other family members covered by this dental insurance:

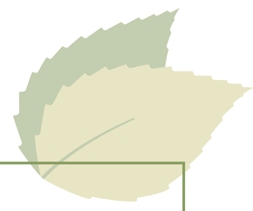
____

AUTHORIZATION

I hereby authorize payment directly to Dr. Lee Zuidema and Dr. Jeremy Hess of the group insurance benefits, otherwise payable to me. **I understand that I am responsible for all costs of dental treatment.** I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. **In the event that a health care worker comes in contact with my blood or other potentially infectious bodily fluids while treating me, I hereby consent to a hepatitis and HIV antibody test.** These tests will be at no charge to myself.

X ______________________________ **Date:** ____ /____ /____

SIGNATURE



3 : MEDICAL HISTORY

Patient's Name: ____________________

Physician's Name: ____________________

Phone #: ____________ Date last seen: ___ /___ / ___

Your current physical health is: good fair poor

List any prescription or over-the-counter drugs you are taking:

____________________ ____________________
____________________ ____________________
____________________ ____________________

List any herbal supplements you are taking:

____

Are you allergic to any of the following?

Penicillin	yes
Tetracycline	yes
Erythromycin	yes
Codeine	yes
Sulfa	yes
Ibuprofen	yes
Aspirin	yes
Dental Anesthetics *(Novocaine, Epinephrine, etc.)*	yes
Latex	yes
Metals	yes
Acrylic	yes

Please list any other drugs / foods / compounds that you are allergic to:

____

For Women:

Are you taking birth control pills?	yes
Are you pregnant?	yes (week # ___)
Are you nursing?	yes

For Men:

Do you take nitroglycerin?	yes
Are you taking Viagra?	yes

Have you ever had any of the following diseases or medical problems?

Heart Attack	yes
Heart Murmur	yes
Heart Surgery	yes
Congenital Heart Defect	yes
Mitral Valve Prolapse	yes
Pacemaker	yes
Rheumatic Fever	yes
High Blood Pressure	yes
Low Blood Pressure	yes
Artificial Valves	yes
Atrial Fibrillation	yes
Stroke	yes
Hemophilia / Blood Disorder	yes
Blood Transfusions	yes
HIV + / AIDS	yes
Anemia	yes
Acid Reflux	yes
Tuberculosis	yes
Asthma	yes
Difficulty Breathing	yes
Emphysema	yes
Sleep Apnea	yes
Radiation	yes
Cancer / Chemotherapy	yes
Shingles	yes
Kidney Disease	yes
Artificial Bones / Joints	yes
Diabetes	yes
Hepatitis	yes
Psychiatric Problems	yes
Epilepsy / Seizures	yes
Cold Sores / Herpes	yes
Drug / Alcohol Addiction	yes
Venereal Disease	yes
Ulcers / Colitis	yes
Arthritis	yes
Frequent Headaches	yes
Sinus Problems	yes
Glaucoma	yes

Please list any serious medical condition(s) past or present:

____
____
____

4 : DENTAL HISTORY

Why have you come to the dentist today? ______________________________

____

Are you currently in pain? yes no

Who was your previous dentist? ______________________________

When was your last dental visit? ______________________________

What treatment was done at your last visit? ______________________________

____

Have you ever had a difficult or serious problem associated with any previous dental work? yes no

If "yes," please describe: ______________________________

____

Your current dental health is: good fair poor

Do you like your smile? yes no

Do your gums ever bleed? yes no

How many times a week do you floss?
0 1-3 4-6 Daily

How many times a week do you brush?
1-3 4-6 Daily 2x Daily

Type of bristles? hard med. soft

Do You:

Experience headaches frequently?	yes	________	Times per week
Experience neck pain frequently?	yes	________	Times per week
Expreience jaw pain frequently?	yes	________	Times per week
Experience snoring?	yes	________	Times per week
Wake up frequently?	yes	________	Nights per week
Feel tired during the day?	yes	________	Days per week
Use a C-Pap Machine?	yes	________	If so, how often?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

X ______________________________ Date: ____/____/____
SIGNATURE

5 : COSMETICS

Do you like the color of your teeth?
yes no

Do you like the shape and size of your teeth? yes no

Are you happy with the alignment of your teeth? yes no

What is it that you wish could be changed to improve your smile?

____

____

6 : TMJ

Do you have a clicking, popping, or grating noise in your right or left jaw joint? yes no

Has the noise changed since it began?
yes no

Do you have pain when you chew?
yes no

Do you have pain when you open wide?
yes no

When did you first notice the pain or noise?

____

____

Has your mouth ever locked open or closed? yes no

Do you grind your teeth?
yes no

Have you had a change in your lifestyle such as a change in marital status, childbirth, death in the family, or other stressful events? yes no